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Cambie Corp. Goes to Court

The Legal Assault on Universal Health Care

Colleen Fuller

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ABOUT THE AUTHOR

Colleen Fuller is a research associate with the CCPA who has written extensively on health and pharmaceutical policy in Canada. She is the author of *Caring for Profit: How Corporations Are Taking Over Canada's Health Care System* (New Star Books and the CCPA, 1998), and a co-author of *The Bottom Line: The Truth Behind Private Health Insurance* (NeWest Press and Parkland Institute, 2006) and *Push to Prescribe: Women and Canadian Drug Companies* (Women's Press, 2010). Fuller is a co-founder of PharmaWatch Canada and a member of the Expert Advisory Committee on the Vigilance of Health Products (Health Canada).

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Executive Summary

IN NOVEMBER 2015, the British Columbia Supreme Court is scheduled to hear an unprecedented constitutional challenge to Canada's public health care system. This is not the first or only Charter challenge to provincial and federal medicare laws. However, it poses the most serious threat to the principles of equality and universality that Canada's public health care system is built upon.

This paper takes a brief look at recent attempts by private sector advocates to challenge the right to universal public health care in the courts, with a focus on the current Charter challenge before the B.C. Supreme Court. It reviews the national and international evidence on the role of for-profit providers and payers in efforts to reduce wait times. And it looks at the potential impact a successful bid could have on Canada's most valued and cherished public program: health care.

The B.C. case is being advanced by a group of plaintiffs led by Brian Day, whose clinics are known for billing patients above the fees established by the province and the medical association.[1] In May 2007, the Medical Services Commission (MSC) notified Day that his clinics, Cambie Surgery Centre and the Specialist Referral Clinic, would be audited. This was prompted by dozens of complaints to the MSC from patients who reported the clinics had billed them above allowable amounts.

Accusations had also surfaced that the clinics were charging the public system and patients for the same services, a practice known as double-billing. However, before the audit could get underway, Day and a group of

for-profit clinics took the province to court. The group sought to strike down parts of B.C.'s health care law that they claimed violated the Canadian Charter of Rights and Freedoms, and to have the audit temporarily or permanently quashed.

Day admits that his company, Cambie Surgeries Corporation, is dependent on patients for revenue.[2] But current laws in B.C. protect patients from becoming a source of profit for private investors and clinic owners. Now Day wants the B.C. Supreme Court to agree that doctors and clinics should be able to directly bill patients for medical services, rental of the operating room, and other costs associated with surgery, including nursing and other staff.[3] While wait times appear to be central to the case, the plaintiffs have not asked the Court to rule that doctors should be able to charge only when patients have waited too long in the public system.

The plaintiffs are challenging four sections of the Medicare Protection Act (MPA). These sections prevent doctors enrolled in medicare from billing both patients and the medical plan for the same service; from charging facility fees or extra-billing above the fees established by the medical association; and from charging private insurers for services covered by the Medical Services Plan (MSP). The plaintiffs argue that these rules violate two sections of Canada's Charter of Rights and Freedoms: Section 7 (the right to life, liberty and security of the person) and Section 15 (every individual is equal before and under the law).

The defendants in the Cambie Charter challenge are B.C.'s Minister of Health, the Attorney General, and the MSC. They will rely on both national and international evidence showing that publicly funded universal health care systems are the fairest and most cost-efficient way to provide patients with access to services — without the financial barriers that plague those who live in countries like the United States. They will argue that striking down B.C.'s medicare laws will simply create a health care system where medical care is provided preferentially to those who are able to pay for it, and wait lists will grow longer for the vast majority of the population.

There are a number of interveners in the case. They include the BC Health Coalition and Canadian Doctors for Medicare, individual patients who claim they have been illegally billed for services, and others who will explain that they likely would not qualify for private health insurance under a two-tier system. One intervener group represents patients who originally brought the legal petition to compel the MSC and Ministry of Health to investigate suspected violations of the MPA by private clinics. The B.C. Anesthesiologists Society is also an intervener.

Canada's public health care system reflects a fundamental value shared by a majority of Canadians: medically necessary health care services should be accessible to everyone regardless of income, home province or health status. The public system should be expanded, not contracted, so that services currently outside of the "medicare basket" are accessible to those who need them.

Canadians reject privatization based on their own experience, which is backed-up by the peer-reviewed evidence. That does not mean they are happy with the status quo. Surveys and polls have shown over and over again that people across the country support innovation in the public health care system to enhance access and reduce wait times based on need, not ability to pay. Governments have failed to act, instead turning a blind eye to illegal and fraudulent billing activities that ultimately harm patients.

It is hard to overstate the importance of this litigation. A win for Cambie Surgeries Corporation and its co-plaintiffs would not only undermine the values upon which Canada's health care system is based. As international evidence suggests, it would also undermine our ability to effectively address one of the issues at the centre of the Charter challenge: wait times.

Introduction

"Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care."[4]

—Roy Romanow, from the final report of the Royal Commission on the Future of Health Care (2002)

"Equality is impossible."[5]

—Brian Day, from a presentation to the Fraser Institute (2006)

IN MARCH 2015, the British Columbia Supreme Court will begin hearing a challenge to the provincial Medicare Protection Act (MPA) that, if successful, will have an impact not only on the people of B.C. but on all Canadians in every province and territory.

The plaintiffs, led by Brian Day's Cambie Surgeries Corporation, are asking the Court to declare that B.C.'s health care rules violate the Canadian Charter of Rights and Freedoms. Specifically, the Court will consider whether the ban on user fees, extra-billing and private insurance for medically necessary services is constitutionally defensible.

This is not the first or only Charter challenge to provincial and federal medicare laws. However, it poses the most serious challenge to the princi-

ples of equality and universality that Canada's public health care system is built upon.

This report provides an overview of Cambie's Charter challenge. It puts the case in its historical context, describing how and why Canada's health care system came to restrict private insurance, extra-billing and user fees, and why these measures continue to be critical to the survival of medicare. It reviews the national and international evidence showing that while private payment options may reduce wait times for those who can afford to pay they do nothing to improve overall access in either the public or the private system. Private payment options increase wait times for those who rely on the public system and increase costs overall while providing poorer patient outcomes.

Finally, the report concludes with an assessment of the potential ramifications of the Cambie Charter challenge. The ban on extra-billing, user fees and private insurance for medically necessary services is a central tenet and a key strength of Canada's health care system. Stripped of these regulatory pillars, Canadians can expect to pay more out of pocket for health care whether or not they are privately insured.

The introduction of for-profit health care financing and delivery would usher in a U.S.-style two-tier health system with significant additional, unnecessary administrative costs, producing inequitable access to services, and an emaciated public system acting as the provider of last resort for those unable to pay their way to the front of the queue.

Legal and Legislative Context

MEDICARE RESTS ON a complex web of arrangements among federal and provincial governments, each administering their own laws and regulations upholding the right of Canadians to access health services without being driven into poverty or bankruptcy. At the federal level, the Canada Health Act lays out the conditions — including a ban on private insurance for medically necessary services, extra-billing and user fees — that each province must meet to receive federal cash transfers for health.

The provinces, in turn, enact laws that establish which services will be publicly funded. Provincial laws are designed to be consistent with the criteria of the Canada Health Act. In B.C., the purpose of the Medicare Protection Act is to preserve a publicly managed insurance plan and a fiscally sustainable health care system in which access to necessary medical care is based on need and not an individual's ability to pay.

To achieve these objectives, the MPA prohibits extra-billing (charging more than the fees established in the MSP's payment schedule) and the sale of private health insurance for publicly insured health services. It also prevents doctors from collecting fees from the MSP and then charging patients for the same service, a practice known as double-billing. Finally, B.C.'s medicare laws ban facility fees at private surgical clinics, making it illegal for private clinics to charge fees to cover their overheads.

B.C.'s medicare laws do not prevent doctors or clinics from operating on an exclusively private basis. Doctors can legally withdraw from B.C.'s public insurance plan and charge patients directly for publicly insured services at whatever price the market will bear.

Opposition to Universal Health Care

Private insurance, extra-billing and user fees have been flashpoints in the debates about medicare since the beginning of universal coverage in Canada. Supporters of a public health care system assert that access to services must be based on need, while proponents of a private system argue that health care is more akin to other commodities on the market. They argue that user charges deter abuse and overuse of the system, and that access should depend on one's ability to pay.

Many of the most aggressive opponents of a public, universal health care system come from the medical profession and the insurance industry. When Saskatchewan introduced North America's first universal public medical insurance plan in 1962, it triggered a 23-day doctors' strike. By the mid-60s, the Canadian Medical Association (CMA) and the Canadian Health Insurance Association had formed the Canadian Conference on Health Care, bringing together doctors and insurers in a political and ideological alliance vowing to defeat public health insurance.

At its first meeting, industry representatives warned that "government insurance was imminent" and that "doctors' only protection lay in the retention of multiple insurance organizations in the health field." For this reason, doctors heard, "every support should be given to the insurance companies who were fighting the profession's battle."[6]

The passage of the Canada Health Act in 1984 outraged the CMA and many provincial medical associations. Everett Coffin, then-president of the CMA, protested that the Act was "a rape of the spirit, if not the legal stipulations, of the Canadian Constitution."[7] The CMA encouraged its provincial counterparts to undertake a variety of actions to oppose the Canada Health Act, including opting out of medicare, strikes and lawsuits.

This set the tone for the first Charter challenge, filed with the Ontario Supreme Court in 1985 by the CMA and Ontario Medical Association, contesting the legislation's ban on extra-billing and user fees.[8] The claim was eventually dropped, likely due to strong public opposition to these practices.[9]

Since then, medicare has faced four Charter challenges. In 1999, George Zeliotis and Jacques Chaoulli went before Quebec's Superior Court and Appeal Court to contest the province's ban on private insurance payments for public health services. After being heard and rejected twice in the Quebec courts, the men successfully appealed to the Supreme Court of Canada.

In a controversial and divided judgment in 2005, the Court ruled that Quebec's ban on private insurance violated the Quebec charter. Three of the seven judges at the Supreme Court also found that the ban violated Section 7 of the Canadian Charter of Rights and Freedoms, another three found there was no such violation, and one judge restricted her analysis to the Quebec charter. The application of the ruling did not extend beyond Quebec.

The Chaoulli decision was followed in 2006 by three more Charter challenges: one in Ontario (Shona Holmes, still pending), one in Alberta (Darcy Allen), and the most recent case in B.C. (Cambie, et.al.). In April 2014, Allen's case was rejected in Alberta's Court of Queen's Bench. The third Charter challenge, launched by Day, co-owner of both Cambie Surgery Centre and the Specialist Referral Centre in Vancouver,[10] contests the provincial ban on extra-billing, user fees and private health insurance.

Events Leading Up to the Charter Challenge

In May 2007, the MSC notified Day it had received information about possible extra-billing at the Cambie Surgery Centre and the Specialist Referral Clinic, both of which he is heavily invested in. The MSC had received correspondence from some 30 patients who reported having been billed between $400 and $17,000 for services covered under the province's medicare plan. "In many cases," the MSC commissioner said, "the practitioner who rendered the surgical services also submitted a claim to [the Medical Services Plan, or MSP] for visits or other services." The MSC informed Day that both clinics would be audited.[11]

But before the MSC was able to conduct an audit, Day's Cambie Surgeries Corporation, along with four other private clinics, launched a Charter challenge to the province's Medicare Protection Act. They asked the B.C. Supreme Court to declare that the Act prohibited access to private health care and patient choice, and requested that the Court "stay or enjoin" the MSC's audit until a final determination on their claim.[12]

The Court agreed to a temporary stay of the audit, which finally took place in 2012. At that time the MSC uncovered extensive illegal billings amounting

to nearly $500,000 over a period of less than 30 days at the Cambie Surgery Centre and Specialist Referral Clinic. The audit also found $66,000 in overlapping claims — evidence that pointed to double-billing for the same service.[13]

The MSC further discovered that patients at the Cambie and Specialist Referral clinics, referred to as the "Extra Billing Clinics," were required to sign a waiver or "acknowledgement form" pledging they would not seek reimbursement from the MSP for the cost of surgery they received. Patients also had to agree "not to disclose any information to any government regarding the particulars of the beneficiary's surgery," including costs. If the patient did disclose, the waiver "require[d] the beneficiaries to indemnify the Extra Billing Clinic for damages and costs arising from [the] disclosure."[14]

The Charter Challenge

Cambie Surgeries Corporation et al. v. Medical Services Commission et al.

EXTRA-BILLING AND FACILITY fees are at the centre of the Cambie Charter challenge. Although Day argues that the ability to pay privately will alleviate wait times, neither Cambie nor any of the other plaintiffs in the case are asking the Court to rule that Canadians must be guaranteed a right to access health care in the public system in a timely manner. In fact, the plaintiffs are asking the Court to affirm a physician's constitutional right to charge patients for care regardless of how long a patient has been waiting for care, or indeed whether they have been waiting at all.

Day is arguing that, under the Charter, doctors should be able to charge patients for their services, and that B.C. should lift the provincial ban on the sale of private health insurance for publicly insured services. He and the co-plaintiffs are challenging the following sections of the Medicare Protection Act:

> **Section 14 (Election)**: Enrolled doctors can opt out and bill the patient instead of the MSP. In these cases, the patient applies for reimbursement from the MSP; the physician cannot bill both the patient and the MSP for the same service. Doctors also cannot bill above the tariff negotiated between the government and Doctors of BC.

The Plaintiffs

The B.C. Charter challenge was originally launched by five for-profit clinics: Cambie Surgeries Corporation, False Creek Surgical Centre, Inc., Delbrook Surgical Centre, Inc., Okanagan Health Surgical Centre, Inc., and Ultima Medical Services, Inc. They were joined by the Canadian Independent Medical Clinics Association, of which Brian Day is past-president.

In June 2010, all of the surgical companies except Cambie Surgeries Corporation withdrew from the Charter challenge and were replaced by the Specialist Referral Clinic. Two years later, a number of patients joined Day as plaintiffs. Four of the patient plaintiffs who have received services at both Cambie and the Specialist Referral Clinic had had their fees reduced or waived.[15]

Two of the plaintiffs claim they faced unacceptably long wait times in the public system for treatment of injuries, leading them to seek treatment at a private clinic. They assert that as a result of long wait times they developed further joint damage, and that this negatively impacted their future prospects and/or quality of life.

One plaintiff with colon cancer who accessed care in the private sector argues that the anticipated waiting period of seven months in the public system denied her access to an early intervention that was critical to the success of her treatment.

Finally, one plaintiff is a teenage boy who was diagnosed at age eight with scoliosis, a condition that causes severe curvature of the spine. He claims he sought surgery in a private hospital in the United States after being unable to access surgery in B.C., and, as a consequence of the delay, is now paralyzed.

Section 17 (General limits on direct or extra-billing): An enrolled and opted-in physician cannot bill a patient directly for a service included in the MSP, or for "materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit."

Section 18 (Limits on direct or extra-billing by a medical practitioner): Physicians who are or are not enrolled and who practise in a public hospital or community care facility may not bill more than the tariff negotiated between the government and Doctors of BC. This restriction does not apply to non-enrolled physicians practising in a non-hospital facility.

Section 45 (Private insurers): Physicians may not charge private insurers for a service included in the MSP. This only applies to physicians who are enrolled in the MSP.

The Defendants

The defendants in the case are the B.C. Minister of Health, the Attorney General, and the B.C. Medical Services Commission (MSC). The province will argue that a parallel private tier does not reduce wait times for patients using the public system. It plans to show that wait times increase because physicians have incentives to delay surgery in the public system so that patients are attracted or forced into the private system. The province will rely on evidence from other jurisdictions to also make the following points.

The ban on private health insurance: The province argues the demand for duplicate private health insurance is associated with reduced quality of care. They will submit evidence showing that individuals with higher income and education levels are more likely than others to purchase, and benefit from, duplicate private insurance, while those who cannot afford it have more limited access to care and coverage.

The impact of private providers on the public system: The province will also make a number of arguments that allowing private health providers to access private payments will have a negative impact on the public system for these reasons:

a) Private clinics restrict their practices to less complicated cases, leaving public hospitals with a relatively more complex and expensive case mix;

b) The existence of private insurance does not simply shift demand from the public to the private system, but stimulates an overall increase in demand for health care; and

c) Competition between private and public health care systems for a finite supply of physicians, nurses and technicians increases the overall cost of those health human resources, pushing up the cost to the public health care system.

Conflict of interest: The province will point to ethical concerns that can arise when doctors have ownership interests in the private clinics to which they refer privately insured and higher paying patients. This has emerged as a significant issue in the United States, where regulations have been passed to block Medicare payments to physicians for treating patients they have referred to surgical hospitals in which they own shares or equity.

The province has launched a number of very serious counterclaims against the plaintiff clinics. The Minister of Health Services, one of the defendants, is seeking damages for economic losses the province has suffered due to reduced federal transfer payments, a penalty imposed on British Columbians because of extra-billing practices at the clinics. The minister is also asking the Court for a declaration that the "acknowledgement forms" used by the clinics are void and unenforceable, and that the clinics must stop requiring patients to sign them.

The Interveners

There are a number of interveners in the case. One group is composed of the BC Health Coalition, Canadian Doctors for Medicare, two individual patients, and two physicians practising in B.C. The two patients have had long-term and serious health issues. They argue that because of their minimal resources they could not receive the care they require if care was provided based on income, and that they would not qualify for private insurance.

This group will introduce evidence from two expert witnesses. The first will describe the impacts of the Chaoulli decision in Quebec and underscore the ways in which the Cambie Charter challenge represents a much broader and potentially far more harmful attack on the public health care system. The other expert will describe the high costs and negative health impacts that private health care and health insurance would have for Canada.

Also intervening in the case is the British Columbia Anesthesiologists Society, as well as the group of patients who originally petitioned the Medical Services Commission and Ministry of Health to investigate suspected violations of the Medicare Protection Act by private clinics.

The MSC, another defendant, has filed a separate counterclaim against the plaintiff clinics. It is seeking a warrant authorizing an inspector to enter the clinics to copy their records and those of the physicians practising in them. The MSC is also asking the Court to make declarations that there is reason to believe the Cambie and the Specialist Referral Clinic have contravened the Medicare Protection Act's limits on direct- or extra-billing, and to issue an order restraining the clinics from contravening the *Act*.

Differences Between the Day and Chaoulli Charter Challenges

MANY PEOPLE HAVE drawn comparisons between Day's Charter challenge and the 2005 Chaoulli decision in Quebec. While there are similarities, the two cases are quite different.

In the Quebec case, plaintiffs argued the ban on private insurance for services covered under the province's public health insurance system violated both the Quebec Charter of Human Rights and Freedoms and the Canadian Charter of Rights and Freedoms. But they did not dispute laws preventing physicians from extra-billing or double-billing patients and insurers for the same service. The Supreme Court was split, 3-3, in its decision on the question of whether the ban on private insurance for publicly insured services violated the Canadian Charter. But it ruled 4-3 that the ban violated the Quebec charter.[16] In other words, the fundamental question of whether a ban on private health insurance offends the Charter remains to be resolved..

Even though the Chaoulli decision was more limited in scope than what the plaintiffs in the B.C. case are seeking, it has already had a negative impact on the public health care system. Since 2005, Quebec has seen a significant increase in the number of private clinics whose doctors have opted out of medicare. There has also been an increase in illegal billing practi-

ces by opted-in physicians — practices that critics suggest the province has done nothing to stem.

According to La Régie de l'assurance maladie du Quebec (RAMQ, the province's health plan), "only 20% of the opted-in medical clinics in Quebec had practices that were in conformity with legal requirements regarding patient billing for accessory fees."[17] In Quebec, extra-billing is referred to as an accessory fee.

Zeliotis, the patient in the Chaoulli case, had sought relief in the courts after waiting two years for hip surgery. But today the length of time Quebec residents are waiting for access to hip surgery is remarkably similar to other jurisdictions, a benchmark achieved not through the Supreme Court but with innovative public policies that targeted wait time reductions.[18]

But illegal billings in Quebec have increased significantly since Chaoulli. In 2014, five organizations representing health care activists, retirees and pro-medicare doctors launched a class action lawsuit against extra-billing clinics, as well as against the Minister of Health and RAMQ for failing to uphold the public interest.[19]

In the Chaoulli case, the Supreme Court found that Quebec patients should be able to obtain private health insurance "where the public system fails to deliver reasonable services." But that is not the remedy being sought by the B.C. plaintiffs, who are asking the Court to legalize extra-billing, user fees and private insurance, not to decrease wait times in the public system. If they are successful, it will affect the ability of the Canada Health Act and every provincial health insurance plan to allocate access to physician and hospital services according to need rather than ability to pay.

The Evidence

THE GOVERNMENT AND pro-medicare interveners will be able to draw on a robust body of evidence establishing a strong relationship between for-profit facilities that rely on private payment on the one hand and higher costs and longer wait times on the other. Studies also show that, in addition to higher costs, patients treated in for-profit settings have poorer outcomes and higher mortality rates compared to those treated in a non-profit setting, whether public or private.[20]

The introduction of private health insurance as a strategy to reduce wait times across the population has the opposite impact, according to a number of studies. In England, for example, "regions in which many [individuals] are privately insured appear to put fewer [public] resources into keeping waiting lists short."[21] It is likely that evidence-based recommendations for public strategies to reduce wait times — submitted to federal, provincial and territorial governments from professional associations,[22] health coalitions,[23] the (now-defunct) Health Council of Canada,[24] the Wait Times Alliance[25] and the Senate,[26] — would be undermined by the introduction of private payment options.

Most experts recognize that international comparisons of wait times are difficult since half of the countries in the OECD, including Switzerland, France and Germany, do not regularly monitor or collect data on wait times.[27] It is even difficult to compare wait times among countries that do collect data, as there is no standardized method for measuring them. Different countries use different start points (e.g., initial referral, first specialist appointment)

and end points. In addition, the use of waiting times data as a way to monitor and measure access to services has limitations, according to one study, "not least because statistics do not contain the information required to assess whether time waited is appropriate to need."[28]

Comparisons are challenging even between provinces within Canada, and for similar reasons: there are too few national standards or benchmarks. During the past decade, in particular, provinces have developed wait-time tables, but these are still characterized by significant methodological limitations; standardization across provincial jurisdictions has proved very difficult.

What is true in all provinces without a common queue is that only surgeons (and not the province or health authority) decide which patients will receive surgery, when and in what order. In these cases, neither hospital staff or health authorities nor the province moves patients between surgeons, although patients, in consultation with treating physicians, should be able to exercise this option. It is at the surgeon's sole discretion whether surgery is classified as urgent or elective.

Growth in For-Profit Clinics

Most for-profit clinics in Canada were established during and after the mid-1990s when hospital closures and bed reductions created an opening for private entrepreneurs interested in cashing in on opportunities created — sometimes intentionally — by provincial governments intent on reducing health expenditures by delisting or cutting back public health services.[29] While public policy was a significant factor in the growth of for-profit clinics, advances in surgical technology and anesthesia supported increases in the number of procedures that could be performed on an outpatient basis in non-hospital facilities.

Between 1995 and 2000, the number of cataract and knee replacement surgeries, most of which could be performed on an ambulatory basis, increased by 66% and 92% respectively in B.C.[30] During the same period, across Canada, the percentage of surgeries performed on an outpatient basis increased from approximately 70%[31] to 87%, giving the country the highest rate of outpatient surgeries in the world.[32] Most outpatient surgery takes place in a public hospital setting, but many provinces have also allowed private investors to become established in this area.

By 2006, there were approximately 72 for-profit surgical facilities in Canada providing publicly insured services, 25 of them in British Columbia.[33]

Many for-profit clinics have clustered in certain specialties, particularly eyes, hips and knees, and in cities with greater population density.

A comprehensive review by the Ontario Health Coalition in 2008 found that a majority of private facilities charged patients directly for services, violating provincial legislation and the Canada Health Act. "A substantial portion of the for-profit clinics," the report noted, "maximize their revenues (and their profit) by combining billings to the public plan with direct charges wherever they can within and outside of Canadian law, using [Workers' Compensation Board] (or equivalent), third party and out-of-country customers, and direct charges to patients."[34]

What does the evidence say about the contribution of private, for-profit providers to wait time reductions in Canada and internationally? This is an important question, since the number of private clinics has increased over the last 20 years across Canada. While there may be differences in how or whether countries gather wait time data, private provision and financing of care have not made a significant contribution to wait time reductions in the public system — anywhere.[35]

A 2010 synthesis of the international evidence found that private health insurance had no impact on public sector wait times, while private clinics were associated with lower quality and higher costs. For-profit providers were more likely to choose services that could be provided on a high-volume basis (and therefore most profitably), and to choose patients with few or no complications, a practice known as risk selection or, more commonly, cherry picking.

A recent article in the *New York Times* noted that in the U.S. market-based system, "patients can get lucrative procedures rapidly, even when there is no urgent medical need." But those who are elderly or have complex and urgent needs, such as asthma or diabetes, can wait weeks "or longer if you need to find a doctor who accepts your insurance plan or Medicare."[36]

There is also evidence in Canada that private for-profit clinics charging facility fees and/or extra-billing are not making the contribution to reduced wait times that many of their investors and supporters claim. A paper by Wendy Armstrong found that a parallel system of cataract surgery in Alberta's private sector undermined access to the procedure by patients whose doctors practised in both public and private settings.[37] Similar findings were revealed in a Manitoba study that found patients whose surgeons operated in both a public and private setting had the longest wait times.[38]

A 2011 study commissioned by the B.C. Workers' Compensation Board (WCB) also raises questions about the use of for-profit facilities as a way to

reduce wait times and achieve cost effectiveness. The study by University of British Columbia professor Mieke Koehoorn found that injured workers who required knee surgery were back on the job slightly sooner when they received non-expedited surgery in the public hospital system. (In BC, *expedited* is defined as surgeries performed within 21 days of surgical consult.) The cost was also much higher in the private system. The WCB "paid almost 375% more ($3,222) for an expedited knee surgery performed in a private clinic than for a non-expedited knee procedure in a public hospital ($859)."[39]

Proponents of extra-billing argue that wait times in the public system can be addressed by allowing doctors and private clinic owners to charge patients for medical and hospital services.[40] But medicare supporters in B.C. point to successful efforts at Richmond General Hospital, Mount Saint Joseph Hospital and Lions Gate Hospital, where changes in both professional practice and public policy have cut months from wait times, reduced lengths of stay in hospital, and increased patient satisfaction.[41] These positive changes should be implemented across the province. The voices of health professionals, including surgeons, are crucial in efforts to move governments to apply these and other evidence-based solutions across the system.

Many groups are calling for a renewed Health Accord, which made strides in establishing national benchmarks on wait times. There are also calls for public insurance systems to be expanded to include services not currently covered under medicare and for greater investment in community-based primary health care to ease the burden on hospital emergency departments. Supporters of market-based competition in health care have lobbied governments to re-establish a system that is consistently rejected by a majority of Canadians. Politicians who want to stay in office have resisted calls to completely dismantle what medicare critics call a "government monopoly" in health care.

Since the Charter came into effect, 10 Canadian patients have challenged the constitutional legitimacy of medicare because they felt they had waited too long for surgery. In doing so, they joined patients in other countries who went to court to secure an individual "right" to health care or to pharmaceuticals.[42]

The motives of those relying on the courts are complex and often include efforts to hold governments accountable for funding and policy decisions that may affect public access. But the results suggest the main beneficiaries of favourable court decisions have tended to be those with higher socioeconomic status as well as those selling health care services. Middle-income earners and the poor have not benefitted and, in most cases, access for these groups has worsened.[43]

The Principle of Universal Access

CANADA'S MODERN DAY health care system — its delivery and financing — is a work in progress. The introduction of hospital and medical insurance, or what we refer to as medicare, came after many decades of frequently acrimonious debate. Medical associations, the insurance industry, business organizations and the media lined up against the introduction of a universal health care system.

Organizations representing workers, farmers, women, faith groups and small business began pushing governments to examine how a national, universal health program could be implemented. Notably, these groups did not campaign for the right to pay for health services. Their experiences in a system in which the *right* to pay depended on one's *ability* to pay underpinned their support for a tax-funded medicare program.

In 1961, in response to public pressure, the Diefenbaker government appointed Justice Emmett Hall to lead the Royal Commission on Health Services, whose final report would lay the foundation for medicare. The Commission found that private medical insurance left 40% of Canadians uninsured and many more under-insured, as the existing policies omitted many of the health services patients needed.

The cost to those who were insured was very high: in the case of individual policies, Hall found that for every $2.51 an individual paid in premiums, he or she received $1.00 in medical services, the difference going

to profits and overheads. Among commercial insurers covering group contracts the payout was 62 cents for every dollar received in premiums.[44] Hall also found that significant numbers of Canadians would never qualify for private health insurance due to their pre-existing medical conditions. They were simply deemed uninsurable.

Hall rejected the proposal that government should subsidize people who could not pay so they could purchase private insurance. This would require Canada to establish a comprehensive system of "means testing" to determine who would qualify for subsidies. In addition to those people already income-tested for various welfare programs, Hall noted that between 39% and 66% of income earners would have needed means testing to determine eligibility for publicly subsidized health insurance.[45]

Hall also looked at a number of European countries and the United States to determine what aspects of their health care systems might be successfully adapted to Canada. While he found much to commend in these countries, in the end the commission recommended a system that would suit the unique aspects of Canada's culture, geography and federal system of government. Canadians must "organize our resources in harmony with our favoured situation," Hall wrote, because "all must have access to needed health services through the same door."[46]

Hall's recommendations were reflected in the Medical Care Act of 1966, which launched a unique and distinctly Canadian health care system, one that was highly decentralized and founded on the principle of universal access based on need. The Act left gaps in the public system (e.g., dental, home and long term care, and pharmaceuticals) that remain unfilled to this day. But hospital services, both inpatient and outpatient, and physician care were now within reach for all Canadians on equal terms and conditions, a foundation that reflected core national values.

The Canada Health Act

EXTRA-BILLING BY DOCTORS has been a contentious issue since medicare was introduced. Physician strikes in Saskatchewan (1962), Quebec (1970) and Ontario (1985) focused on the right to bill above the tariff negotiated between medical associations and provincial governments.

Although both extra-billing and hospital user fees were illegal, physicians billed nearly $155 million in 1983 over and above provincial fee schedules, most of that amount in Ontario and Alberta.[47] The number of doctors who extra-billed patients varied by province, from 53% in Nova Scotia to 0.5% in British Columbia,[48] though hospital user fees in B.C. amounted to almost $5.3 million in July 1984 alone.[49]

Ontario's opted-in physicians who had hospital appointments were allowed to run a separate opted-out practice using a payment model that included extra-billing. Under this arrangement doctors could "stream" their more affluent patients to the opted-out practice and refer the others to their practices in the public hospital system.[50] These arrangements were at the centre of a "medicare crisis" in the late 1970s leading to public demands for an outright ban on extra-billing and hospital user charges.[51]

In 1979, the federal government appointed Emmett Hall, who had led the first Royal Commission on Health Services, to review the extent of the violations across the country. He concluded that "the phenomenon of extra billing [was] a grave threat to the principles and, indeed, the very survival of medicare."[52]

Hall's review, combined with strong public demand for an end to such practices, prompted the government to table the Canada Health Act, which passed unanimously in the House of Commons on April 1, 1984. The five principles of the Act — public administration, comprehensiveness, universality, portability and accessibility — received overwhelming support from Canadians.

Although many physicians vehemently opposed a full ban on extra-billing, within a decade of the legislation coming into effect professional opposition to medicare was in sharp decline, with less than 15% in support of a return to private insurance.[53]

Canada and Comparisons to Europe

DAY AND OTHER health care investors point to Europe, especially France, Germany, Belgium and Switzerland, where, they argue, "public and private health care coexist to their mutual benefit and wait lists are virtually non existent in both systems."[54] But if we are to learn anything from the Europeans, it is surely how to reduce private expenditures and expand our public health care system to include dental care, prescription drugs and community-based delivery of many outpatient services that have been delisted or never included in provincial health insurance plans.

When the first for-profit clinic in Canada opened in 1982, the public component of total health care expenditures was 76.2% compared to 70.1% today.[55] That includes public pharmacare programs, home and institutional care, and Aboriginal health services. The percentage of health services included in the "medicare basket," that is, the portion of services actually covered by the criteria of the Canada Health Act, stood at only 42% nationwide in 2004.[56]

This is a very different picture than the one painted by those who support an expanded role for private payers in Canada's health care system. In fact, as University of Toronto professor Colleen Flood has written:

> What distinguishes Canada's health system from others is not how little private finance we have but how much private finance we already endure. Can-

> adians have their health needs covered by the public system only 70 per cent of the time, much less than the U.K. (84 per cent) or Norway (85 per cent) or even France (77 per cent). Indeed, Canadians actually hold more private health insurance than Americans do.[57]

Canadian private health insurers spent $22.7 billion in 2010, about 11.2% of total health expenditures. But the percentage of premium revenue paid out in benefits was only 74%, down from 92% in 1991. In total, Canadians spent almost $6.8 billion more in premiums than they received in benefits in 2011.[58] By way of comparison, the contribution of private health insurance to total health expenditures within the European Union is relatively modest, only exceeding 5% in Austria, France, Germany, Ireland, the Netherlands and Slovenia.[59]

Unlike in the U.S., Canadians are entitled to universal coverage without discrimination based on age, health status or sex, but only under the public insurance system. As a review of the *Canadian Human Rights Act* put it, our human rights law allows private insurers to discriminate on the basis of age, sex and disability in order to "control risks that insurers...feel are necessary to limit costs to keep [benefit] plans affordable."[60]

Private insurers are also able to (and do) discriminate on the basis of ability to pay. This is in stark contrast to public health insurance laws and regulations, which require public health care plans to provide coverage "on equal terms and conditions" to all Canadian residents.

A U.S.-Style System in Canada?

FACILITY FEES FOR outpatient surgical services are a North American phenomenon and one that has become very controversial. The U.S. Medicare Payment Advisory Commission reported in 2012 that Medicare could save between US$1 billion and $5 billion over five years if the facility fee, which provides no added benefit to patients, were eliminated. Seniors, who make up the majority of the 49 million U.S. residents covered by Medicare, and who must provide copayments for services, would save US$250 million annually if the fee were banned.[61] Some U.S. physicians have demanded the government eliminate the facility fee as soon as possible.[62]

Canada and the United States also share similar experiences in regard to surgical clinics, including over-charging, fraudulent billings and rampant conflicts of interest. During the 1990s, ambulatory surgical clinics (ASCs) in the U.S. began to grow in size and number, focusing on specific types of procedures, notably hip and knee replacements. Since then, many ASCs have been acquired by larger competitors, merged or expanded to become what are commonly referred to as specialty hospitals.

Supporters contend that focused missions and dedicated resources can improve quality and reduce health care costs. But critics point to an established pattern whereby physicians who practise in specialty hospitals often own shares in them, select the least risky patients, siphon off the most prof-

itable procedures and fail to provide other vital community health services needed by patients who have undergone surgery.[63]

Specialty hospitals have been accused of eroding the financial health of general hospitals, which are left with fewer human resources but sicker patients.[64] Critics also contend that physicians who invest in a specialty hospital and then refer patients to the hospital in which they own shares or equity have financial incentives that negatively affect their clinical judgments. About 70% of U.S. specialty hospitals are owned, in whole or in part, by physicians.[65]

Since the mid-1990s, stand-alone facilities like the Cambie Surgery Centre have characterized the for-profit surgical "sector" in Canada, but this is changing and following a pattern similar to the United States.

Centric Health is a Canadian corporation based in Toronto but supported with U.S. venture capital.[66] The company is investing heavily in the health sector and is now established in 980 locations across the country. A growing part of Centric's investment portfolio is in for-profit surgical facilities. Between 2009 and 2011, Centric acquired 14 new companies in seven provinces,[67] including the Vancouver-based False Creek Surgical Centre, Winnipeg's Maple Surgical Centre, and Canadian Surgical Solutions in Calgary.

Centric aims to operate a full spectrum of health services, encouraging patients to sidestep the public system altogether. In addition to surgical facilities, it now operates over 60,000 long-term care beds, and employs over 3,400 health professionals, consultants and other staff.[68] About 51% of the company's revenue is in physiotherapy; Centric has come to dominate the field since 2011 when it acquired LifeMark, Canada's largest rehab company with 120 clinics.

The company has also embarked on an aggressive physician recruitment strategy to ensure it has access to "the necessary professional medical and support staff to support its expanding operations."[69] To that end, Centric has conducted a review of legislation, regulations and ethical codes across the country and found that regulators in Canada have expressed no concern about potential conflicts of interest. Though the company recommends that doctors "should provide patients with adequate disclosure of their purchase of Units and offer such patients a freedom of choice in connection with such referrals," there is nothing to inhibit health care professionals from buying or owning shares in Centric while working for the company and providing services simultaneously in the public system.[70]

The ban on extra-billing and user fees has enabled Canadian provinces to avoid the steep regulatory and administrative burden found in the U.S.,

where in 2004 health care regulation cost up to $340 billion out of a total health expenditure of $1.7 trillion.[71] In spite of such high expenditures, fraud costs the U.S. health system $75 billion annually.[72] These are costs that Canadians simply cannot afford. Yet if we allow the market to expand in health care we will either have to regulate it or anticipate the much higher costs associated with not regulating.

Day's remedy for the Canadian health care system is not European, as he suggests. It is modelled on a costly U.S. system, founded on the "right to pay," which blocks millions of people from accessing the care they need and deserve.

Conclusion

THE PLAINTIFFS IN *Cambie Surgeries Corporation et al. v. Medical Services Commission et al.* hope to build on the 2005 Chaoulli decision, in which the Supreme Court of Canada ruled, controversially, that Quebec patients should have access to private insurance where wait times are too long. But the goals in British Columbia are much more radical. The B.C. Charter challenge appears to be focused almost exclusively on eliminating the ban on extra-billing and user fees, regardless of whether patients experience long wait times. As we have seen, the implications for public health care across Canada are enormous.

If Canadians want to know what health care would look like should the Cambie Corporation win this case, they can turn to their experiences with private health and dental insurance. The number of Canadian workers with employer-sponsored health and dental benefits has been declining in Canada since the late 1990s. In 2005, the last year for which Statistics Canada data are available, only 40% of Canadian workplaces offered health-related benefits, covering 51.3% of employees for health and 56.1% for dental.[73] In 2014, the percentage of workers in B.C. with employer-sponsored health benefits (excluding dependents) stood at 36%, one of the lowest rates in the country. [74]

Canada can benefit from the experience of international peers, including the United States and countries in Europe. Those that have adopted a two-tier or multi-tier health care system have not seen any additional benefit; in most of these cases patients wait longer for services in the public sys-

tem. In Canada, private insurance is an unlikely option for the vast majority of people. Up to 80% of the money spent by employer-sponsored health benefit plans is for prescription drugs.[75] It is doubtful these extended benefit plans will be able to support additional costs associated with the provision of surgical and other services delivered by companies like the Cambie Surgeries Corporation. Employers confronting escalating costs associated with private health care goods and services have already cancelled or reduced benefits for hundreds of thousands of working people in Canada, including retirees.[76]

If Canada's public system is depleted of physicians and other health care workers those without private workplace benefits would face a struggle to access health care services on the same terms and conditions that exist today under medicare. The uninsured (and uninsurable) would likely have to submit to a means test to determine eligibility for a public subsidy, something that was rejected by the Hall Commission as demeaning and degrading. As Day told an audience in 2013, "you [would] simply exclude [the poor] from paying user fees. For sure some type of means test is going to have to exist."[77]

Canadians are open-minded about health care reform. They are willing to look at experiences in other provinces and countries to see what works. But polls indicate they are not inclined to support the right to pay over other considerations, including changes in the public health care system that will reduce wait times. Rather, a majority of Canadians tend to believe, as Roy Romanow expressed in 2002, "it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care."

There is growing interest in expanding medicare to include dental, vision care, prescription drugs, outpatient rehabilitation services, long-term care and home care, just like they have in Europe. Canadians are also interested in greater public investment at the primary health care level. Surveys and polls have shown that people across the country support innovation in the public health care system designed to enhance access and reduce wait times. Governments have had strong support for positive, public reforms since medicare was first introduced. It is time for them to act on this mandate.

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